STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155757	B. WIN			03/26/	2012
		_			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		7510 R	OSEGATE DR		
	ATE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
F0000	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE		DATE
F0000							
	TP1 · · · ·	C 41 T 4: 4:	F00	000	Please accept this 2567 Plan	of	
	This visit was for the Investigation		100	00	Correction for the Complaint	OI .	
	of Complaints	s IN00104048 and			Survey ending March 26, 201	2 as	
	IN00104412.				the Provider's Letter of Credil	ole	
					Allegation. This Provider		
	Complaint IN	00104048 -			respectfully requests a Post Survey Revisit on or after Api	-il	
	_	Federal/State			16, 2012.	-	
	deficiencies re						
	allegations are	e cited at F157, F223,					
	F282, F309 ar	nd F425.					
	Complaint IN	00104412 -					
	1 -						
		ed. Allegation did					
	not occur.						
	Unrelated defi	iciency cited					
		•					
	Survey dates:						
	1	e- 0.6 - 2012					
	March 15, 23	& 20, 2012					
	Eggility Nymal	or: 011140					
	Facility Numb						
	Provider Num						
	Aim Number:	200829340					
	Survey Team:						
	I						
	Mary Jane G.	LISCHEL KIN					
	Census Bed T	Type:					
	SNF: 34	~ <b>.</b>					
	1 ~~ ,- , - , - , -		ı		1		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

011149

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757  A. BUILDING B. WING		<u>00</u>	COMPLETED 03/26/2012				
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	SNF/NF: 106 Total: 140						
	Census Payor Type: Medicare: 43 Medicaid: 78 Other: 19 Total: 140 Sample: 6 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/29/12 by Suzanne Williams, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 2 of 62

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155757	B. WING	<del></del>		03/26/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROSEGA	TE VILLAGE				OSEGATE DR APOLIS, IN 46237		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DROVIDERIG IV AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0157 SS=D	resident; consult and if known, not representative or member when the resident which the potential for rintervention; a signesident's physical status (i.e., a det or psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, confereatment); or discharge the resident and, if known there is a consequence assignment as specified in sessignment as specified in resident and, if known there is a consequence assignment as specified in resident and, if known there is a consequence assignment as specified in resident and, if known there is a consequence assignment as specified in resident and assignment as specified in resident and assignment as specified in resident and i	NE/ROOM, ETC) Immediately inform the with the resident's physician; tify the resident's legal r an interested family Here is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial terioration in health, mental, estatus in either life litions or clinical In need to alter treatment In a need to discontinue an reatment due to adverse or to commence a new form In a decision to transfer or Insident from the facility as					
	update the addre	record and periodically ess and phone number of the epresentative or interested					
	Based on recor	rd review and	F015	57	F- 157 – Notify of Changes		04/16/2012
	interview, the	facility failed to			What corrective action(s) will		
	ensure a reside	ent's physician was			be accomplished for those		
	immediately n	otified, in that when			residents found to have been affected by the deficient	l 	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 3 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155757	A. BUI B. WIN			03/26/2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹				
DOCEC	ATE VIII ACE				OSEGATE DR	
RUSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	a resident had	breathing difficulties			practice?	
	and displayed	increased edema, the			· Resident "B" was	
	1 -	· · · · · · · · · · · · · · · · · · ·			discharged from the facility on	
	nursing staff f	alled to act			2/20/12.	
	immediately a	and inform the			How will you identify other residents having the potential	, l
	resident's phys	sician for intervention			to be affected by the same	XI
					deficient practice and what	
		cline in the resident's			corrective action will be take	n?
	condition, for	1 of 3 residents			All residents having	
	reviewed with	specific physician			changes in condition have bee	en
		nple of 6. [Resident			identified. Physician(s) have b	een
		ilple of o. [Resident			notified and residents have be	
	"B"].				placed on "hot charting" (chan	
					of condition) until condition(s)	are
	Findings inclu	ıde:			stable and/or resolved.	4-
	i mamgs mera	ide.			What measures will be put in place or what systemic	ito
					changes you will make to	
	The record for	r Resident "B" was			ensure that the deficient	
	reviewed on 0	3-15-12 at 11:30 a.m.			practice does not recur?	
					· Charge nurse who	
		luded but were not			identifies the change in conditi	ion
	limited to acu	te renal failure,			will contact the resident's	
	peritonitis, her	maturia, asthma,			physician to communicate the	
	cirrhosis and l	nenatic			change.	
		•			· Charge nurse will	
	encephalopath	y. These diagnoses			document all nursing actions/interventions in the	
	remained curr	ent at the time of the			nurse's notes and will add the	
	record review.				resident to the "Hot Charting" I	list
		•			7 days a week and each shift.	
					DNS and/or designee w	rill
	The record inc	dicated the resident			ensure daily, to assure	
	had recently b	een discharged from			documentation of the changes	in
	_	ospital on 12-05-11			condition and appropriate	
		-			follow-up has been addressed and physician has been notifie	
		o the facility with			Nursing staff will be	ou.
	instructions for	or the nursing staff to			in-serviced by Director of Nurs	sina
		mation: MD for			and/or designee on April 3, 4,	
		manon, wid to			5, 2012 on physician notification	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLETED
		155757	B. WING			03/26/2012
			1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	ER .		7510 R	OSEGATE DR	
	ATE VILLAGE			INDIAN	APOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	How the corrective action (s)	
	_	cites, abdominal pain,			will be monitored to ensure t	
	confusion or	temperature of >			deficient practice will not rec	
	[greater] 100	.5." In addition, the			i.e., what quality assurance	
	resident had a	a physician order for			program will be put into plac	e?
		t, if at or about 5 lbs.			A CQI audit tool will be utilized to monitor compliance	
	-	week or 3 lbs. in 24			with reporting changes of	
		me of physician]."			condition by the Director of	
	Hours can [Ha	ine of physicianj.			Nursing and/or designee. Nursing and/or designee. Nursing notes observations will be	e's
					completed weekly X 4 weeks,	
	Review of the	e resident's current			monthly X 2 months, and	
	plan of care d	lated 02-02-12,			quarterly thereafter for at least	
	indicated "Pr	oblem cirrhosis."			two quarters until compliance been achieved.	has
	"Approach -	approach start date			Results of these evalua	tion
		serve for altered			processes will be presented to	)
	1	, increased pain,			the CQI Committee monthly to	)
		* *			review for compliance and follow-up. Identified	
	abdominal di				noncompliance may result in	
	· · · · · · · · · · · · · · · · · · ·	/v [nausea/vomiting],			development of action plans, s	staff
	increased we	akness/debility,			re-education and/or disciplinar	У
	decreased app	petite."			action.	
	A subsequent	plan of care dated				
	1	licated "Acute renal				
	· · · · · · · · · · · · · · · · · · ·					
	_	proach - approach				
		13-11, observe for s/s				
	signs and sy	mptoms] of SOB				
	[shortness of	breath], increased				
	edema, pain or elevated B/P [blood pressure], refer to MD [Medical					
Doctor] as needed."						
	Doctor as ne	cucu.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 5 of 62

	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757			ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/26/2012
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
ROSEG	ATE VILLAGE			OSEGATE DR IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	An additional 02-02-12 indirisk for fluid in diuretics and "Approach - a 12-05-11 - ob dehydration/f pale mucous intenting, decressod [shortne increased ede increased wts abdominal girk. Review of the indicated the "02-17-12 at a [heart rate] 92 93% on room 138/70, T [ter [respiratory racurrently, no pain, minor Sibreath], no dy breathing]. Pudesire any introccasional NE	plan of care dated cated "Resident is at mbalance related to fluid restriction." approach start date serve for s/s of luid overload: dry membranes, skin ased urinary output, ss of breath], dyspnea, ma, lethargy, . [weights], increased th."			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 6 of 62

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/26	ETED
	PROVIDER OR SUPPLIER		7510 RG	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	downward] volumes and rhore [bilateral] experiencement. BS [bilateral] experiencement appear slightly Pt. states had be evening (02-16 reg. [regular] be extremities]."  "02-18-12 at 0 [B/P] 127/76, saturation 90 % 20, T 96.7. Pt diminished all inspiratory / expresent. Pt. c/ (5/10). Interveneb. [nebulize pain tx. with peresent tx. with peresent ty. Wit	clume with crackles in achi present bil. iratory wheezing powel sounds] 4, abdomen does of distended, but soft. BM yesterday 6). Pulses equal / BUE [bilateral upper  100 [1:00 a.m.] P 108, oxygen on room air, RR c/o SOB, lungs are lobes with expiratory wheezing on pain in back also antion inhaler 2 puffs, and trn [as needed] ain medication]. Presexygen [90%, sing, post intervention g downward] p breathing and O2				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 7 of 62

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/26	ETED
	PROVIDER OR SUPPLIER		7510 RG	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	pitting edema extremities]. It with minor must "02-19-12 at 2 [abdomen] first LS [lung sound [expiratory] which cough with ground with ground must be supposed by the supposed				RIATE	
	Pt. has c/o pair	n importance of				
	coughing to pratelectasis/pne					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 8 of 62

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757		LDING	NSTRUCTION 00	(X3) DATE COMPL 03/26/	ETED
	PROVIDER OR SUPPLIER		B. WIN	7510 RG	DDDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	edema 3+ - he to] severe abdoputting pressur lungs. Keepin elevated > [gred degrees."  "02-20-12 [dagrees."  "outpure and a second approximately when the day second approximately	y shift] BP 115/61, % - room air, 20. [Arrow pointing [pounds] - called Dr. port [arrow pointing ain - Dr. wants res. to [name of local ER [emergency . [evaluation]."  the nurse assessed 11:15 p.m., the not notified of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 9 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155757	A. BUILD	ING	00	COMPL 03/26/	
		130707	B. WING	CED DET.	DDDEGG GUTY GTATE GID GODE	03/20/	2012
NAME OF F	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE  DSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		0:00 a.m., titled		IAG			DATE
		inge of Condition,"					
		•					
	and dated as "						
	indicated the f	following:					
	# <b>P</b> OT TOTAL	11. 1 7. 2. 4					
	_	ld type] It is the					
		facility that all					
	changes in res	ident condition will					
	be communication	ated to the physician					
	and family/res	sponsible party, and					
	that appropria	te, timely and					
	effective inter	vention occurs."					
	"PROCEDUR	E - 2. Acute Medical					
	Change						
		n or serious change in					
		ndition manifested by					
		nge in physical or					
	mental behavi	•					
		to the physician					
	_	for physician visit					
	promptly and/						
	evaluation. T	he licensed nurse in					
	charge will no	tify the physician."					
	This Federal to	ag relates to					
	complaint INC	00104048.					
	3.1-5(a)(3)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 10 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CC  A. BUILDING  B. WING	00				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COI OSEGATE DR	DE			
ROSEGA	TE VILLAGE		INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ECTION ULD BE PROPRIATE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 11 of 62

-	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155757		LDING	00	COMPLETED 03/26/2012
		100707	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2012
NAME OF I	PROVIDER OR SUPPLIER				OSEGATE DR	
ROSEGA	ATE VILLAGE				APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIAT	TE COMPLETION DATE
F0223 SS=D	483.13(b), 483.1 FREE FROM AB SECLUSION The resident has verbal, sexual, p corporal punishm seclusion.  The facility must sexual, or physic punishment, or in Based on reconsinterview, the ensure a resided verbal abuse in dependent resident resident addition, which impaired resident physical behave Certified Nurse continued to in completed which the behaviors of resident.  This deficient a resident resident. This deficient a residents revealed.	a(b)(1)(i) BUSE/INVOLUNTARY  If the right to be free from hysical, and mental abuse, nent, and involuntary  Into use verbal, mental, real abuse, corporal hyoluntary seclusion.  Ind review and facility failed to ent was free from he that when a dent required care, arses aide verbally ident.  Interpolation of the properties of the prope	F02		F223- Free from Abuse/ Involuntary Seclusion  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident F was discharge from this facility on 1/21/12.  Resident C resides at the facility and is treated with dign and respect during CNA care. Employees were in-serviced on Abuse, and The Elder Justice and Misappropriation of Prope on April 10, 2012, by Facility Administrator.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take All residents have the potential to be affected and are free of staff to resident abuse.  Residents were assessed.	04/16/2012  I n ged ne ity n Act rty  I n? e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 12 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE		
		155757	B. WING			03/26/20	12
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
DOOFOA	TE \		7510 ROSEGATE DR				
	ATE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES	,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	Findings inclu	· · · · · · · · · · · · · · · · · · ·			and interviewed for feelings of		
	i mamgs mere				safety, using the QIS question	~ 1	
	1 771	C D			tool by the Social Service staff As a result of this questioning		
	1. The record for Resident ""C"				resident voiced that they were		
		on 03-23-12 at 9:45			abused.		
		a.m. Diagnoses included, but were not limited to, rheumatoid arthritis,			Decidents with escalation		
	l				<ul> <li>Residents with escalating behaviors have been identified</li> </ul>		
	hypertension,	depression anxiety,			with behavior management pla	ans	
	severely defor	rmed hands/feet/digits			developed and implemented.		
	with hyper extension and insomnia.  These diagnoses remained current				Care plans for behavior management have been		
					developed and Care tracker h	as	
		the record review.			been updated.		
					What measures will be put ir	ıto	
	Davious of the	211-08-11 Minimum			place or what systemic		
					changes you will make to		
		ssment indicated the			ensure that the deficient		
	resident had n	-			practice does not recur?  CNAs were in-serviced	on	
	impairment of	r memory loss.			Dealing with the Combative ar	_	
					Agitated resident by Social		
	A review of fa	acility provided			Service Staff on 10, 2012.		
	reportable inc	idents to the ISDH			Nursing will be in-servi	ced	
	indicated the	following:			on the Behavior Management		
		C			program on April 12 and 13, 2 by Social Service Director.	012	
	  "[Resident] si	ibjected to alleged			2, 200.0. 00. 7100 21100.011		
		by CNA [certified			· All Staff in-service on	A -4	
		mployee #13, and			Abuse, and The Elder Justice and Misappropriation of Prope		
	_	•			on April 10 and 12, 2012 by th		
		resident was a "pain			Facility Administrator.		
		This incident occurred			Continued in-servicing of the c	<sub>on</sub>	
		petween 10:00 p.m.			Abuse by the SDC Quarterly.		
	and 6:00 a.m.	shift.					
					<ul> <li>Employees are in-service on Abuse in Orientation and</li> </ul>	ced	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	ETED
		155757	B. WIN			03/26/2	2012
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		7510 R	OSEGATE DR		
	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		erview on 03-23-12 at		IAG	periodically during on-going		DATE
		ident "C" indicated			in-service education as neede	d.	
	"Oh that was a	a long time ago. I			· Charge nurse will provide		
	know she said I was a pain in the				supervision to CNA to observe		
		now if she still works			staff to resident interactions or shifts, 7 days a week. Any	1 all	
					inappropriate interactions will I	be	
		it she doesn't take			addressed and documented		
	care of me."				immediately.		
	Eurther record	Leavious of the facility			How the corrective action (s)		
	Further record review of the facility				will be monitored to ensure t	_	
		n CNA employee #13			deficient practice will not rec i.e., what quality assurance	ur,	
	indicated the f	following:			program will be put into plac	e?	
	"[Name of CN	IA] verbalized she			A CQI audit tool will be		
	worked on 08-	-28-11 from 10:00			utilized by the Director of Nurs	ing	
	p.m. to 6:00 a	.m. and [name of			and/or designee to monitor compliance with Abuse		
	_	Name of CNA			Prohibition, Reporting and		
	_	] verbalized that			Investigation. Audits will be completed weekly X 4 weeks,		
		5 hours of her shift			monthly X 2 months, and		
	_	resident] was on			quarterly thereafter for at least		
	_	ery 15 - 20 minutes."			two quarters until compliance achieved.	io	
		her indicated she			Results of these evaluation		
		sident's room about			processes will be presented to the CQI Committee monthly to		
		and the resident			review for compliance and	,	
					follow-up. Identified		
		nave pillows moved,			noncompliance may result in action plans, staff re-education	_	
		p in bed, to fill water			and/or disciplinary action.	Ī	
		ace on the bedpan.					
	The CNA indi	icated other staff					
	helped her thr	ough the shift and					
	_	the individuals.					
		ee #13 indicated that					
		on 15 indicated that					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155757	A. BUILDING	00	03/26/2012
		100707	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹		OSEGATE DR	
ROSEGA	ATE VILLAGE		INDIAN	IAPOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION DATE
	"at one point t	hat her and [name of			
	CNA employee #14] were in the				
	resident's roor	n taking [resident] off			
	the bedpan and	d the resident was			
	complaining the	hat no one will do			
	anything for [1	resident]. CNA			
	employee #13	verbalized to the			
	1	e being a pain in the			
		ıldn't point that out to			
	1 *	port further indicated			
	_	loyee #13 "is acting			
	different and i	s doing this because			
	[resident] wan	its to be in control."			
	D : 641	C 11:4 : 1 1			
		facility provided			
		the Resident on			
		cated the following:			
	_	1 after 10 p.m. staff 'pain in the a**.'			
		aide came in room on			
		casions last night			
		e first time resident			
		a pillow for elbow			
		lent] has a big thing			
	_	or legs and to close			
		lent voiced aide did			
		d. Resident voiced			
		erable night and could			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 15 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 03/26/2012
	PROVIDER OR SUPPLIER	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	not go to sleep. The second time resident asked aide to place her on bed pain <sic>, which the aide placed on <sic> resident on bed pan. The third time when aide came in she was accompanied by another aide and told her [in reference to the resident] was a 'real pain in the a**.' Resident informed writer, [resident] is not scared but 'it is just the way she talked to me that I did not like. I did not think it was right."'  The facility indicated they placed CNA employee #13 on a performance improvement plan as the CNA "did not promote dignity and self respect to resident when she spoke inappropriately to resident."  Review of the employee file for CNA #13 indicated she continued to work at the facility until she resigned on 02-01-12.  2. The record for Resident "F" was reviewed on 03-26-12 at 11:30 a m</sic></sic>			
	reviewed on 03-26-12 at 11:30 a.m.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 16 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE  A. BUILDING  B. WING	00	COM	TE SURVEY  MPLETED  26/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	limited to, infl dementia, dem and depression	luded, but were not ammatory colitis, nentia with behaviors, n. These diagnoses ent at the time of the					
	The 12-07-11 Minimum Data Set assessment indicated the resident had cognitive impairment with short and long term memory loss.						
	Review of the facility provided information related to an allegation of abuse with this resident and CNA employee #12 indicated the following:						
	01-05-12 at ab employee [CN [CNA employ of Resident "F providing care was combative employee #15 employee #12 but CNA emp	[A #15] witnessed ee #12] 'swat' [name "] on right arm while to the resident who e. [Name of CNA					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 17 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED 03/26/2012	
		155757	B. WIN		PRESIDENCE STREET, STR	03/20/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X	<i>'</i>
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E COMPLI	
		room until care was					
	_ •	ensure resident safety					
	_	ediately reported					
	incident to sup						
	1						
	"[Name of CN	[A employee #12]					
	verbalized that	t resident was					
	combative and	l verbally aggressive					
	when she and	[name of CNA					
	employee #15	attempted to give					
	shower earlier	in the shift.					
	Resident conti	nued to be combative					
	with care and	was showing					
	increased restl	essness while the					
	CNAs were at	tempting to get the					
	resident dresse	ed. The nurse					
	attempted to g						
	medications by	ut [resident] spit them					
	out. [Name of	FCNA employee #12]					
	verbalized wh	ile providing care the					
	resident had k	icked and hit her."					
	UENT CON	(A 1 //4.63					
	_	[A employee #15]					
		ner interview that					
		[name of CNA					
		] transfer resident,					
	= =	ted punching [name					
	_	oyee #12] in the					
	stomach. Whi	le [resident] was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 18 of 62

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757			LDING	NSTRUCTION  00	(X3) DATE COMPL 03/26	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
	hitting her, [C. 'swat' at reside of CNA employer [name of CNA] leave the room finish resident CNA employer leave the room room to ensure after she and [employee #12] went and reposupervisor. [Nemployee #15] did not feel the employee #12 but out of frus were interview to substantiate intentional. Eshad an involute put her hands 'My reflex mare [resident] but hands in the aid investigation of that abuse occ CNA employer.	ents right arm. [Name byee #12] to a and she would 's care, but [name of the #12] refused to a. So she stayed in the resident's safety, name of CNA left the room she ret incident to						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 19 of 62

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	- COM 03/2	e survey pleted 6/2012	
	PROVIDER OR SUPPLIER ATE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	previous care accompanying and education.	disciplinary actions					
	01-05-12 at 8:	nurses notes dated 00 a.m. indicated the arrence with the					
	Resident kicki and punching took 3 people [resident] beca combativeness repeatedly trie						
	2:10 p.m. licer #5 indicated sl the incident w the CNA's, ho was unaware i members to sh resident. "The backed away."	ower and dress the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 20 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155757	B. WIN	G		03/26/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DOOLOA	TE VIII A O.E.				OSEGATE DR		
RUSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  S LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	when she advised CNA employee #12 to leave the room, licensed						
	1	ee #5 indicated the					
		nave put on the call					
	_	hed the care herself.					
	I didn't hear about it until						
	afterwards."						
	Review of CNA employee #12 file						
	indicated she	had been involved in					
	instances of "i	inappropriate					
		th a resident" on					
		gation against					
		"may constitute					
		on 08-11-09 and					
	•	minated on 01-05-12					
		erate treatment of a					
	resident."						
	3. Review of	the Facility policy on					
	03-15-12 at 9:	15 a.m., titled "Abuse					
	Prohibition, R	eporting and					
		" dated February					
		ed the following:					
	"It is the notic	y of American Senior					
	_						
		•					
		~ ~ ~					
	abuse, sexual	abuse, verbal abuse,					
	"It is the polic Communities from abuse in	ed the following:  ry of American Senior to protect residents cluding physical abuse, verbal abuse,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 21 of 62

	OF CORRECTION  IDENTIFICATION NUMBER:  155757	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/26/2012			
	PROVIDER OR SUPPLIER ATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE  7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds."						
	"DEFINITIONS OF ABUSE - Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish."						
	"Physical abuse [underscored] includes hitting, slapping, pinching, and kicking."						
	"Verbal abuse [underscored] defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident's or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability."						
	This Federal tag relates to complaint IN00104048.						
	3.1-27(a)(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 22 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757		: A. B <sup>1</sup>	A. BUILDING  B. WING			COMPLETED 03/26/2012		
	PROVIDER OR SUPPLIER ATE VILLAGE	B. W	STREET ADDRESS, CITY, STATE, ZIP CODE  7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PERCEDED BY REGULATORY OR LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE		
	3.1-27(b)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 23 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO			COMPL	ETED
ı		155757	B. WIN			03/26/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OSEGATE DR		
ROSEGA	ATE VILLAGE		INDIANAPOLIS, IN 46237				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services pro facility must be p in accordance w plan of care.	QUALIFIED PERSONS/PER evided or arranged by the provided by qualified persons with each resident's written	502	92			04/17/2012
l		rd review the facility e physician orders	F0282		F- 282-Services by Qualified Persons/Per Care Plan		04/16/2012
	and plans of cathat when a recorders for medications at and failed to for 2 of 6 samp [Residents "B"]  Findings inclusion. The record was reviewed a.m. Diagnoson to limited to, peritonitis, her cirrhosis and hencephalopath	are were followed, in sident had physician dications and assistive cility failed to ensure ceived the and devices as ordered, collow the plan of care pled residents.  ', "E"].  de:  d for Resident "B" on 03-15-12 at 11:30 es included, but were acute renal failure, maturia, asthma, nepatic y. These diagnoses ent at the time of the			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident "B" was discharged from the facility on 2/20/12, before the chart was reviewed.  Resident "E" was discharged from the facility on 3/18/12, before the chart was reviewed.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take  All residents with person alarm orders have been identified. Resident's beds an wheelchairs have been audite ensure alarms are in place in accordance with each resident written plan of care and Care tracker updated.  All residents MARs have been reviewed for medications that have been withheld. Residents identified as having medications withheld due to medication unavailable, have been identified and identified as having medication unavailable, have been medication unavailable, have been affected by the same deficient practice and care tracker updated.	n? nal d to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 24 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155757	B. WIN			03/26/2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OSEGATE DR	
ROSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE
	Review of the	resident's current			pharmacy notified and medications have been sent p	er
	plan of care da	ated 02-02-12			physician orders.	
	indicated "pro	blem - asthma."			What measures will be put in	to
	•	pproach start date			place or what systemic	
		minister med's			changes you will make to	
					ensure that the deficient	
	[medications] as ordered."				practice does not recur?  An in-service will be	
					completed by the Director of	
	A review of th	ne resident's physician			Nursing and/or designee on A	pril
		bruary 2012 included			3, 4, & 5, 2012 to licensed nur	
		•			regarding facility processes fo	l l
		d 12-05-11 for Advair			medication administration and delivery of medications.	
	diskus [a bron	chodilator] 250/50 -			The Director of Nursing	
	inhale 1 puff of	every twelve hours.			Services and/or designee will	
	The inhaler w	as scheduled to be			assign a licensed nurse to rev	iew
		at 9:00 a.m. and 9:00			the medication and treatment	
		at 9.00 a.m. and 9.00			administration records daily to ensure medications have been	
	p.m.				administered per physician	1
					orders.	
	Review of the	February 2012			<ul> <li>The Director of Nursing</li> </ul>	
	medication ad	ministration record			Services and/or designee will	
		resident did not			conduct personal alarm audits daily to ensure alarms are in	
					place per physician order. Car	re l
		naler as prescribed at			plan and Care tracker will be	
	9:00 a.m. and	9:00 p.m. and			updated accordingly. (Care	
	February 13th	and 14th and again			tracker is an electronic CNA	
	1	n February 15th			assignment sheet)	
					How the corrective action (s) will be monitored to ensure t	
	[2012].				deficient practice will not rec	
					i.e., what quality assurance	,
	The reverse si	de of the medication			program will be put into plac	e?
	administration	record indicated the			A CQI audit tool will be	
	following:				utilized by the Director of Nurs	ing
	_	voir 250/50			and/or designee to monitor compliance with medication	
	"02-13-12 adv	/aii 230/30			administration. Audits will be	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155757	B. WIN			03/26/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
DOCEO/	ATE VIII A OE				OSEGATE DR	
	ATE VILLAGE		ı		APOLIS, IN 46237	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE COMPLETION DATE
					completed weekly X 4 weeks,	
	unavailable - phar. [pharmacy] notified."				monthly X 2 months, and	
		250/50 :1-1-1-			quarterly thereafter for at least two quarters until compliance i	
		250/50 unavailable -			achieved.	5
	phar. notified.				· A CQI audit tool will be	
	"02-14 advair	250/50 unavailable."			utilized by the Director of Nurs	ing
	"02-15 advair	250/50 unavailable -			and/or designee to monitor compliance of residents with	
	phar. notified	said sent on 01-23-12			personal alarms. Audits will be	,
	- found botton	n drawer at 1:30 p.m."			completed weekly X 4 weeks,	
		•			monthly X 2 months, and quarterly thereafter for at least	
	1b The recor	d indicated the			two quarters until compliance i	
	resident had re				achieved.	
		•			<ul> <li>Results of these evaluate processes will be presented to</li> </ul>	
		m a local area			the CQI Committee monthly to	
	_	-05-11 and returned			review for compliance and	
		with instructions for			follow-up. Identified	
	_	aff to "Contact			noncompliance may result in development of action plans, s	staff
	information:	MD for worsening			re-education and/or disciplinar	
	ascites, abdom	ninal pain, confusion			action.	
	or temperature	e of > [greater]				
	100.5." In add	dition, the resident				
		n order for "daily				
	weight, if at or	•				
	•	week or 3 lbs. in 24				
	i nouis can [nai	ne of physician]."				
	<b>.</b>					
	ĺ ,	hen the resident had a				
	decline/change of condition, the nursing staff failed to follow the resident's current plan of care for					
		pproaches as follows:				
	1					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 26 of 62

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155757	A. BUILDI	NG	00	03/26/	
		100707	B. WING	STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/20/	
NAME OF I	PROVIDER OR SUPPLIE	ER.			OSEGATE DR		
ROSEGA	ATE VILLAGE		1	NDIAN	APOLIS, IN 46237		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX ΓAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	ΓE	COMPLETION DATE
	Review of the	e resident's current					
	plan of care dated 02-02-12,						
	indicated "Pro	oblem cirrhosis."					
	"Approach - a	approach start date					
	12-13-11, obs	serve for altered					
	mental status	, increased pain,					
	abdominal di	stention and					
	discomfort, n/v [nausea/vomiting],						
	increased wea	akness/debility,					
	decreased app	petite."					
	_	plan of care dated					
		licated "Acute renal					
	_	proach - approach					
		13-11, observe for s/s					
	1	mptoms] of SOB					
	_	breath], increased					
		or elevated B/P [blood					
	_	er to MD [Medical					
	Doctor] as ne	eded."					
	A 111/2	1 C 1 1					
	_	plan of care dated					
	*	licated "Resident is at					
	risk for fluid imbalance related to						
		fluid restriction."					
		approach start date					
		oserve for s/s of					
	denydration/f	luid overload: dry					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 27 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757		A. BUILDING  B. WING			COMPLETED 03/26/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	tenting, decreaes SOB [shortness increased edentincreased wts. abdominal girth Review of the indicated the formula of the indicated of the indicat	[weights], increased h."  nurses notes ollowing:  245 [10:45 p.m.] HR oxygen saturation air, [blood pressure] aperature] 98.2, RR tel 18. No needs to [complaints of] OB [shortness of spnea [difficulty in patient] does not rvention at this time, [non productive] [arrow pointing lume with crackles in achi present bil. ratory wheezing sowel sounds] 4, abdomen does distended, but soft.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 28 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL		
		155757	B. WIN			03/26/	2012
	PROVIDER OR SUPPLIER			7510 RG	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	evening (02-10 reg. [regular] I reg. [regular] I extremities]."  "02-18-12 at 0 [B/P] 127/76, saturation 90 % 20, T 96.7. Pt diminished all inspiratory / expresent. Pt. c/ (5/10). Interveneb. [nebulize pain tx. with p Tramadol [a p treatment O2 [ shallow breath [arrow pointin wheezing, dee 98 %. Pt. A & oriented] time palpable bil. [I pitting edema extremities].	BUE [bilateral upper  100 [1:00 a.m.] P 108, oxygen on room air, RR c/o SOB, lungs are lobes with expiratory wheezing o pain in back also ention inhaler 2 puffs, r] tx. [treatment] and ern [as needed] ain medication]. Pre foxygen 90%, ening, post intervention g downward] p breathing and O2		TAG		AIE	DATE
	[abdomen] firi	:00 p.m Abd. m / dist. [distended] ds] slightly exp.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 29 of 62

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  00 COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:  155757		LDING	00	03/26/		
		100707	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/	2012	
NAME OF I	PROVIDER OR SUPPLIE	R			OSEGATE DR			
	ATE VILLAGE				APOLIS, IN 46237			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	[expiratory] v	vheezes - productive						
	cough with g	reen sputum - MD						
	notified. Res	. req. [requested]						
	Pro-air [an in	haler] at 1:45 p.m. for						
	wheezing, +	effective, +2 pit.						
	[pitting] eden	na to BUE [bilateral						
	upper extrem	ities], bruising noted						
	to BUE"							
		2315 [11:15 p.m.]						
	[BP] 116/67,	P 102, T 97.8, O2						
	93% room aii	r, RR 20. Pt. has c/o						
	SOB also who	eezing present at this						
	time. Inspira	troy / expiratory, lung						
	sounds dimin	ished throughout.						
		h Duoneb [inhaler].						
		in in shoulder.						
	Educated pt.	on importance of						
	turning deep	breathing and						
	coughing to p							
		eumonia. Abd.						
		BLE [bilateral lower						
		oitting edema 3+ -						
		d d/t [due to] severe						
		stension putting						
	_	iaphragm and lungs.						
	Keeping HOB [head of bed]							
		reater than] 30						
	degrees."							
	1						I	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 30 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155757	B. WIN			03/26/	2012
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
ROSEGA	ATE VILLAGE				OSEGATE DR APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	15	DATE
	[P] 95, O2 92 [respirations] upward] 3.4 # [Doctor] to repupward] wt. geter in the greatest and the resident at physician was resident's concapproximately when the day the resident arresident with a gain.  2a. The record was reviewed p.m. Diagnos not limited to, internal fixation cerebral vascus sided residual.	20. [Arrow pointing [pounds] - called Dr. port [arrow pointing ain - Dr. wants res. to [name of local ER [emergency [evaluation]."]  the nurse assessed 11:15 p.m., the not notified of the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 31 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155757	A. BUI B. WIN	LDING G		03/26/	2012
NAME OF I	DDOVIDED OD CLIDDI IED		B. WIIV		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				OSEGATE DR		
ROSEGA	ATE VILLAGE			INDIAN	APOLIS, IN 46237		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	at the time of	the record review.					
	Review of the	resident's current					
	plan of care, dated 02-28-12						
	indicated "Pro	blem - at risk for					
	constipation d	ue to impaired					
	_	pproach - approach					
	start date 01-0	1-12 - administer					
	medications as	s ordered."					
	A review of th	ne January 2012					
	medication ad	ministration record					
	had a physicia	n order for Senna [a					
	1 .	by mouth every day.					
	The record had	d the dates of January					
	11th and 12th	[2012] circled. The					
		f the record lacked					
	information re	lated to the reason					
	the dates were	circled.					
	Review of the	February 2012					
		ministration record					
	contained a ph	ysician order, dated					
	_	Cholestyram 4 Gr.					
		[powder] - a packet					
		e daily before meals.					
		n administration					
	record had the	dates February 28th					
		2] circled. The					
	_	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 32 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155757		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION 00	COM	E SURVEY PLETED 26/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	the medication	f the record indicated n was "unavailable" ne 29th and the been notified.						
	assessment, da indicated the r and fell off a s <sic> + femor neck fx. right</sic>	f the pre-admission ated 12-29-11 esident "had slipped tool and layed on al fx. [fracture] - hip. Pleasantly d alarm for safety."						
	dated 01-01-12 the nursing sta	ad a physician order, 2 which instructed aff "bed alarm to bed VC [wheelchair] at all times."						
	assessment, da indicated the r cognitive impa extensive assis and bed mobil assessment ind	Minimum Data Set ated 01-08-12, resident had moderate airment and required stance with transfer ity. In addition, the dicated the resident WC alarm in place.						
	The nurses no	tes, dated 02-09-12 at						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 33 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED 03/26/2012
		155757	B. WIN		PPPPG GYPY GT AT GO	03/20/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  OSEGATE DR	
ROSEGA	ATE VILLAGE				APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
		cated the resident was				
	found on the f					
		es aide]. N.O. [new				
	_	alarms for safety.				
	_	Doctor] notified."				
	ivib [ivicaicai	Doctor j notified.				
	A review of th	e "Fall Circumstance				
	Report," dated					
	_	esident was "sitting				
		nes on top none on				
	bottom - unwi	•				
		the time of the fall."				
	The "report" p					
	1 1	was put in to place				
		ther fall?" The				
	_	otation indicated,				
		bed at all times."				
	Bed alalli to	bed at all tilles.				
	A subsequent	physician order dated				
		cated "Clarification -				
	bed alarm to b	ed at all times, check				
		ction qs [every shift].				
	_	v/c at all times, check				
	placement/fun					
	1	1				
	Review of the	resident's plan of				
	care indicated	"Problem start date				
	02-28-12 - res	ident is at risk for				
	falls due to hx	. of falls, fractured				
		•				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 34 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/26/2012	
	PROVIDER OR SUPPLIE	R	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR IAPOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	weakness, communication impairment, a [incontinent] pain and required [activity's of a transfers."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 35 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155757	B. WIN			03/26/	2012
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=G	WELL BEING Each resident me must provide the services to attain practicable physical psychosocial well the comprehensicare.  Based on reconsinterview, the provide and entreceived the highly sical care, resident had be and displayed nursing staff faimmediately attresident's physical care, breath, increase pain and require treatment, for reviewed a same "B"].	Il-being, in accordance with ve assessment and plan of ard review and facility failed to asure a resident ighest practicable in that when a reathing difficulties increased edema, the ailed to act and inform the sician of a decline in condition which ased shortness of sed pitting edema, ring hospital 1 of 3 residents apple of 6. [Resident	F03	09	F- 309-Provide Care/Services Highest Well Being  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident "B" was discharged from the facility on 2/20/12.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken. All residents having changes in condition have been identified. Physician(s) have been identified and residents have been placed on "hot charting" until condition(s) are stable and/or resolved.  What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?  Charge nurse who identifies the change in condition.	n? n een en	04/16/2012
	reviewed on 03	3-15-12 at 11:30 a.m.			will contact the resident's		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 36 of 62

STATEME	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	155757	B. WING		03/26/2012
NAMEOE	OROVIDED OF CLIPPLIED	STREET.	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER	7510 R	OSEGATE DR	
ROSEG	ATE VILLAGE	INDIAN	IAPOLIS, IN 46237	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG		DATE
	Diagnoses included, but were not		physician to communicate the change.	;
	limited to, acute renal failure,		· Charge nurse will	
	peritonitis, hematuria, asthma,		document nursing	
	cirrhosis and hepatic		actions/interventions in the	
	encephalopathy. These diagnoses		nurse's notes and will add the resident to the "Hot Charting"	
	remained current at the time of the		· Charge nurse will	
			document change of condition	
	record review.		days a week and every shift a	and
			call MD for acute change of conditions.	
	The record indicated the resident		Nurse Managers will re	eview
	had recently been discharged from		residents daily with change o	
	a local area hospital on 12-05-11		condition to ensure	
	_		documentation and interventi has been addressed and	on
	and returned to the facility with		physician has been notified.	
	instructions for the nursing staff to		Nursing staff will be	
	"Contact information: MD for		in-serviced by Director of Nur	-
	worsening ascites, abdominal pain,		and/or designee on April 3, 4	
	confusion or temperature of >		5, 2012 on change of conditionand physician notification.	ons
	[greater] 100.5." In addition, the		How the corrective action (s	s)
			will be monitored to ensure	the
	resident had a physician order for		deficient practice will not re	cur,
	"daily weight, if at or about 5 lbs.		i.e., what quality assurance	2
	[pounds] in 1 week or 3 lbs. in 24		program will be put into place.  A CQI audit tool will be	
	hours call [name of physician]."		utilized to monitor compliance	<b>I</b>
			with reporting changes of	
	Review of the resident's current		condition by the Director of	
			Nursing and/or designee. Nul notes observations will be	SE 9
	plan of care dated 02-02-12,		completed weekly X 4 weeks	,
	indicated "Problem cirrhosis."		monthly X 2 months, and	
	"Approach - approach start date		quarterly thereafter for at leas	
	12-13-11, observe for altered		two quarters until compliance achieved.	
	mental status, increased pain,		· Results of these evalua	ation
	abdominal distention and		processes will be presented t	
	WO WOTHING WISCOUT WING		the CQI Committee monthly t	0

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155757		LDING	NSTRUCTION 00	(X3) DATE : COMPL 03/26/	ETED	
	PROVIDER OR SUPPLIER		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	discomfort, n/sincreased weal decreased appe	• •		review for compliance and follow-up. Identified noncompliance may result in action plans, staff re-education and/or disciplinary action.	n	
	02-02-12, indifailure." "Appressant date 12-1 [signs and syntester syntem [shortness of bedema, pain of pressure], refer Doctor] as need.  An addition plocation of the diuretics and for the diuretics and for the diuretics and for the diuretics and for the dehydration of the pale mucous in tenting, decreased eder increased eder increased wts. abdominal girther than the properties of the pale mucous increased eder increased wts.	an of care dated cated "Resident is at mbalance related to luid restriction." pproach start date serve for s/s of uid overload: dry nembranes, skin ased urinary output, as of breath], dyspnea, ma, lethargy, [weights], increased th."				
	Review of the	nurses notes				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 38 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	155757	A. BUII	LDING	00	COMPL 03/26/	
		130737	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/20/	2012
NAME OF F	PROVIDER OR SUPPLIER				OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
	indicated the f	· · · · · · · · · · · · · · · · · · ·		-			
		C					
		245 [10:45 p.m.] HR					
	[heart rate 92, oxygen saturation						
	93% on room	air, [blood pressure]					
	138/70, T [ten	nperature] 98.2, RR					
	[respiratory ra	te] 18. No needs					
	currently, no c	o/o [complaints of]					
	pain, minor SOB [shortness of						
	breath], no dyspnea [difficulty in						
	breathing]. Pt. [patient] does not						
	~ -	ervention at this time,					
		[non productive]					
		[arrow pointing					
		lume with crackles in					
		nchi present bil.					
		iratory wheezing					
	present. BS [b	•					
	_	4, abdomen does					
	*	distended, but soft.					
	Pt. states had l	•					
		6). Pulses equal /					
	• (	BUE [bilateral upper					
	extremities]."	BOL [onatoral apper					
	chicinities].						
	   "02-18-12 at 0	0100 [1:00 a.m.]					
		P 108, oxygen					
		% on room air, RR					
		c/o SOB, lungs are					
	20, 1 70.7. 10	o, o oob, rango are					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 39 of 62

	OF CORRECTION  OF CORRECTION  155757  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155757	(X2) MULTIPLE CC A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 03/26/2012
	PROVIDER OR SUPPLIER ATE VILLAGE	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	diminished all lobes with inspiratory / expiratory wheezing present. Pt. c/o pain in back also (5/10). Intervention inhaler 2 puffs, neb. [nebulizer] tx. [treatment] and pain tx. with prn [as needed] Tramadol [a pain medication]. Pre treatment O2 [oxygen 90%, shallow breathing, post intervention [arrow pointing downward] wheezing, deep breathing and O2 98 %. Pt. A & O [alert and oriented] times three. pedal pulses palpable bil. [bilateral] with 3 + pitting edema BLE [bilateral lower extremities]. Pt. tachacardic <sic> with minor murmur present."  "02-19-12 at 2:00 p.m Abd. [abdomen] firm / dist. [distended] LS [lung sounds] slightly exp. [expiratory] wheezes - productive cough with green sputum - MD notified. Res. req. [requested] Pro-air [an inhaler] at 1:45 p.m. for wheezing, + effective, +2 pit. [pitting] edema to BUE [bilateral upper extremities], bruising noted to BUE"</sic>			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 40 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155757			LDING	NSTRUCTION  00	(X3) DATE COMPL 03/26/	ETED	
	PROVIDER OR SUPPLIER		p. why	STREET A	ODDRESS, CITY, STATE, ZIP CODE  DSEGATE DR  APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[BP] 116/67, If 93% room air, SOB also whe time. Inspirate sounds dimini Will treat with Pt. has c/o pair Educated pt. of turning deep be coughing to prove at the coughing	n importance of creathing and cevent cumonia. Abd. BLE [bilateral lower atting edema 3+ - d/t [due to] severe tension putting aphragm and lungs. [head of bed] ceater than] 30  by shift] BP 115/61,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 41 of 62

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155757	A. BUII		00	COMPL 03/26/	
		100707	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/	2012
NAME OF P	PROVIDER OR SUPPLIER	1			OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
		ER [emergency					
		l. [evaluation]."					
	room for eval. [evaluation].						
	From the time	the nurse assessed					
	the resident at 11:15 p.m., the						
		not notified of the					
	resident's cond						
		6 1/2 hours later,					
	when the day shift nurse weighed the resident and discovered the						
	_	a 3.4 pound weight					
	gain.						
	Daview of the	facility policy on					
		0:00 a.m., titled					
		inge of Condition,"					
		•					
	and dated as ":						
	indicated the f	ollowing:					
	   "POLICY [ka	ld type] It is the					
	-	21 3					
	policy of this						
	_	ident condition will					
		ated to the physician					
	· ·	sponsible party, and					
	that appropria	•					
	effective inter	vention occurs."					
	"DDOCEDID	E 2 April Madical					
		E - 2. Acute Medical					
	Change						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 42 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155757  A. BUILDING  B. WING			COMPL: 03/26/	ETED		
	PROVIDER OR SUPPLIER		7510 RC	NDDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	a resident's con a marked chan mental behavior communicated with a request promptly and/of evaluation. The	to the physician for physician visit or acute care ne licensed nurse in tify the physician."				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 43 of 62

-	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155757	B. WIN			03/26/2	:012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  OSEGATE DR		
ROSEGA	ATE VILLAGE			INDIANAPOLIS, IN 46237			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0323 SS=D	483.25(h) FREE OF ACCID HAZARDS/SUPP The facility must environment rem hazards as is po receives adequa assistance device Based on obse review and interpolate	ensure that the resident sains as free of accident ssible; and each resident te supervision and es to prevent accidents. Evation, record erview, the facility e supervision and es were provided for spaired residents to ng staff of unassisted safer, in that when a history of falls, and prior to admission to a fall risk, the nursing provide assistive the nursing staff of bulation/transfers for s reviewed for falls 6. [Resident "E" and	F03		F- 323 – Free of Accident Hazards/Supervision/Devices  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident "E" was discharged from the facility 3/18/12.  Resident "D" was immediately assessed and identified to be high-risk for fall Tag alarm was placed per physician order and her fall riscare plan was updated with ne individualized interventions. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take.  All residents have the potential to be affected.  Fall risk assessments for all cognitively impaired resident information.  Care plans for cognitive impaired residents identified a fall risk have been reviewed to	IIs. IIs. Isk ew al	04/16/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 44 of 62

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVE	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155757	B. WIN			03/26/2012	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	· ·		7510 R	OSEGATE DR		
ROSEG	ATE VILLAGE			INDIAN	IAPOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		on due to fracture,			ensure appropriate interventio are in place.	ns	
	cerebral vascular accident with left				· All residents with Physic	ian	
	sided residual	, and constipation.			ordered personal alarms have		
	These diagnos	ses remained current			been identified. Resident's be	ds	
	_	the record review.			and wheelchairs have been audited to ensure alarms are in	,	
	Review of the pre-admission assessment, dated 12-29-11, indicated the resident "had slipped and fell off a stool and layed on <sic> + femoral fx. [fracture] -</sic>				place according to Physician	.	
					orders. The Plan of Care and		
					Care tracker has been update	d	
					accordingly.		
					What measures will be put in place or what systemic	ا ا	
					changes you will make to		
					ensure that the deficient		
					practice does not recur?		
	neck fx. right	hip. Pleasantly			Residents who are new		
	confused. Be	d alarm for safety."			admissions/readmissions and identified as being cognitively		
					impaired and high-risk for falls	will	
	The resident h	ad a physician order,			have prevention interventions		
		2, which instructed			initiated per individualized care	•	
					plan and Physician orders. Licensed nurses will		
		aff "bed alarm to bed			conduct rounds daily on all shi	fts.	
		VC [wheelchair]			on residents with care plan	,	
	alarm to chair	at all times."			interventions for personal aları	ns	
					to ensure interventions are in		
	Review of the	Minimum Data Set			place and functioning.  All falls will be discussed	,	
					and fall circumstance report	1	
	assessment, da				reviewed by the Interdisciplina	ry	
	indicated the i	resident had moderate			team the next business day to		
	cognitive imp	airment and required			discuss other possible		
	extensive assi	stance with transfer			interventions to prevent future falls. Care plan and Care track	er	
	and bed mobil	lity. In addition, the			will be reviewed and updated		
		dicated the resident			needed.		
					How the corrective action (s)		
	nau a bed and	WC alarm in place.			will be monitored to ensure t		
					deficient practice will not rec i.e., what quality assurance	ui,	
	1		1		i.c., what quanty assurance		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155757	B. WIN			03/26/2012
NAME OF P	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	ATE VILLAGE				OSEGATE DR APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
1710		resident's plan of	+	1710	program will be put into plac	
		"Problem start date			<ul> <li>A CQI audit tool will be</li> </ul>	
		ident is at risk for fall			utilized to monitor compliance with prevention interventions of	of .
					residents at risk for falls by the	• • • • • • • • • • • • • • • • • • •
	due to hx. of falls, fractured right hip, impaired mobility, weakness, confusion, cognitive impairment,				Director of Nursing and/or	
					designee. Resident observation will be completed weekly X 4	1115
	·	• •			weeks, monthly X 2 months, a	
	•	t, incont. [incontinent]			quarterly thereafter for at least two quarters until compliance	• • • • • • • • • • • • • • • • • • •
		dder, pain and			achieved.	
	requires assist				A CQI audit tool will be	
		laily living] and			utilized by the Director of Nurs and/or designee to monitor	ing
		pproach - approach			compliance of residents with	
	start date 01-0	1-12 Bed alarm, chair			personal alarms. Audits will be	<b>;</b>
	alarm."				completed weekly X 4 weeks, monthly X 2 months, and	
					quarterly thereafter for at least	
	The nurses no	tes, dated 02-09-12 at			two quarters until compliance achieved.	is
	3:30 p.m., ind	icated the resident			· Results of these evaluate	tion
	was found on	the floor per CNA			processes will be presented to	• • • • • • • • • • • • • • • • • • •
	[certified nurs	es aide]. N.O. [new			the CQI Committee monthly to review for compliance and	
	order] for bed	alarms for safety.			follow-up. Identified	
	MD [Medical	Doctor] notified."			noncompliance may result in development of action plans, s	etaff
	-	-			re-education and/or disciplinar	• • • • • • • • • • • • • • • • • • •
	A review of the	ne "Fall Circumstance			action.	
		102-09 [2012],				
	_	resident was "sitting				
	on floor - clothes on top none on bottom - unwitnessed, and incontinent at the time of the fall."  The "report" prompts "what					
		_				
	miervention (s	s) was put in to place				

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	155757	A. BUILDING	00	COMPLETED 03/26/2012
		199797	B. WING		03/20/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE  OSEGATE DR	
ROSEG <i>A</i>	ATE VILLAGE			IAPOLIS, IN 46237	
(X4) ID		STATEMENT OF DEFICIENCIES	ID ID	<u>,                                      </u>	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	to prevent and	other fall?" The			
	handwritten notation indicated,				
	"Bed alarm to bed at all times."				
	A subsequent	physician order dated			
	•	icated "Clarification -			
	•	ped at all times, check			
		nction qs [every shift].			
	_	w/c at all times, check			
		nction qs [every			
	_	iction 48 levery			
	shift]."				
	2 The mesend	for Docidant IIDII			
		for Resident "D" was			
		93-23-12 at 9:30 a.m.			
	_	eluded, but were not			
		pertension, severe			
		congestive heart			
	failure, conge	stive heart failure and			
	depression. T	hese diagnoses			
	remained curr	ent at the time of the			
	record review	•			
	Review of the	pre-admission			
		sessment," dated			
		indicated the resident			
		n at times, and bed			
	alarm for safe				
		cy.			
	The regident's	Minimum Data Set			
	The resident s	wininium Data Set			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 47 of 62

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155757		LDING	NSTRUCTION 00	(X3) DATE COMPL 03/26/	ETED	
	PROVIDER OR SUPPLIER		7510 R	ODDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	indicated the r cognitive impa extensive assis bed mobility a Review of the	"fall risk lated 03-09-12,				
	"confused and/or disoriented," and prompted the nursing staff to "proceed to care plan with appropriate interventions based on risk factors."					
	indicated "Pro 03-09-12 - Fal weakness/seve incontinence, impairment, re antidepressant tube feeding- requires assist transfers."	s, g [gastrostomy] continuous, pain and for ADLs and  pproach start date alarm on at all times				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 48 of 62

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155757	A. BUI	LDING	00	COMPLETED 03/26/2012
		133737	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/20/2012
NAME OF P	PROVIDER OR SUPPLIER				OSEGATE DR	
ROSEGA	ATE VILLAGE				APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
		·				
	The resident h	ad a physician order				
		2, for "bed alarm on				
	at all times. C	heck every shift				
	positioning an	d function."				
	During observ	ation on 03-23-12 at				
	_	person who identified				
	self as a "friend" to the resident was					
	seated in a chair adjacent to the					
	resident's bed	and waving towards				
	the doorway.	When requested to				
	enter the "frien	nd" indicated "yes,				
	come look at [	resident], [resident]				
	keeps trying to	get up and I'm				
	afraid to leave	and [resident] might				
	fall. [Residen	t] keeps getting up				
	and I tell [resid	dent] to sit back				
	down." Durin	g this observation the				
	resident was s	eated in a wheelchair				
	with the bedsi	de table in front of				
	[resident]. Th	e resident attempted				
	to stand, but w	ith encouragement				
	from "friend"	sat back down in the				
	wheelchair.					
	A licensed nur	rse was immediately				
	notified. How	ever, the nursing				
		assess the resident for				
	safety while se	eated in a wheelchair,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 49 of 62

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155757	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 03/2	TE SURVEY  SPLETED  26/2012		
	PROVIDER OR SUPPLIER ATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	and provide an assistive device to alert the nursing staff of unassisted ambulation/transfer.						
	3.1-45(a)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 50 of 62

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		ONSTRUCTION 00	(X3) DATE S COMPLI	ETED
		155757	B. WIN	G		03/26/	2012
	ROVIDER OR SUPPLIER			7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG F0425 SS=E	(EACH DEFICIEN REGULATORY OR 483.60(a),(b)	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  CAL SVC - ACCURATE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	PROCEDURES, The facility must emergency drug residents, or obtagreement descipart. The facility personnel to adripermits, but only supervision of a A facility must preservices (including the accurate acquand administering biologicals) to miresident.  The facility must services of a lice provides consult provision of pharmacy and administering biologicals and admin	provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed ninister drugs if State law under the general licensed nurse.  It is procedures that assure uiring, receiving, dispensing, g of all drugs and eet the needs of each  employ or obtain the ensed pharmacist who ation on all aspects of the enacy services in the facility. It review and facility failed to ations, in that when a ered medications for a accility failed to ensure in was provided from and administered to or 4 of 5 residents nedications in a Residents "B", "E",	F04	25	F- 425-Pharmaceutical SVC-Accurate Procedures, RF What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  Resident "D" medication administration record was immediately assessed for medications that were withheld with no negative outcomes not Resident "B," was discharged from facility on 2/2 2012.  Resident "E," was discharged from facility on 3/13 2012.	i n d ted.	04/16/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 51 of 62

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155757	B. WIN			03/26/	2012
			<b>В.</b> WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			OSEGATE DR		
ROSEGA	ATE VILLAGE				APOLIS, IN 46237		
						ı	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION DATE
IAU	REGULATORT OR	LESC IDENTIFTING INFORMATION)		TAG	· Resident "F" was		DATE
					discharged from facility on		
	1. The record	for Resident "B" was			1/21/2012.		
reviewed on 03-15-12 at 11:30 a.m.				How will you identify other			
		luded, but were not			residents having the potentia	al	
	_				to be affected by the same		
	limited to, acu	ite renal failure,			deficient practice and what		
	peritonitis, her	maturia, asthma,			corrective action will be take		
	cirrhosis and h	nenatic			All residents' medication  administration records have be		
		y. These diagnoses			administration records have be reviewed for medications that	<del>ce</del> n	
		· -			have been withheld. Reasons	for	
	remained current at the time of the				withholding the medication have		
	record review.	<u>.</u>			been documented in the nurse		
					notes and/or the back of MAR		
	D : C41				· Residents identified as		
		resident's current			having medications withheld d		
	plan of care da	ated 02-02-12,			to medication unavailable, have had pharmacy notified and	/e	
	indicated "pro	blem - asthma."			medications have been sent p	er	
	•	pproach start date			physician orders.		
					· All residents with reque	est	
	12-13-11 - adı				to hold medications per		
	[medications]	as ordered."			resident/family request have b		
					identified. Physicians have been	en	
	Δ review of th	ne resident's physician			notified and nursing actions/interventions have bee	an an	
					documented in the medical	<b>211</b>	
		bruary 2012 included			record.		
	an order, dated	d 12-05-11 for Advair			What measures will be put in	ito	
	diskus [a bron	chodilator] 250/50 -			place or what systemic		
	_	every twelve hours.			changes you will make to		
		•			ensure that the deficient		
		as scheduled to be			practice does not recur?		
	administered a	at 9:00 a.m. and 9:00			<ul> <li>Residents requiring regularly scheduled medication</li> </ul>	ne	
	p.m.				to be withheld will have the fro		
	1				of the medication record for th		
	D : 0.4	F.1 2012			dose initialed and circled, and	an	
		February 2012			explanatory note entered in the		
	medication ad	ministration record			nursing notes and/or the back	of	
					the medication administration		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155757	B. WIN			03/26/	2012
	PROVIDER OR SUPPLIER TE VILLAGE SUMMARY S	TATEMENT OF DEFICIENCIES		7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	i E	DATE
		resident did not			record.  • An in-service will be		
	receive the inf	naler as prescribed at			completed by the Director of		
	9:00 a.m. and 9:00 p.m. and				Nursing and/or designee on A 3, 4 & 5, 2012 to licensed nurs		
	February 13th	and 14th and again			on medication administration.		
	at 9:00 a.m. oi	n February 15th.			· The Director of Nursing		
	The reverse si administration following: "02-13-12 adv unavailable - protified." "02-13 advair phar. notified. "02-14 advair "02-15 advair phar. notified - found bottom In addition, the orders for Rifa for diarrhea] to	de of the medication a record indicated the vair 250/50 phar. [pharmacy]			Services and/or designee will assign a licensed nurse to revite medication and treatment administration records daily to ensure medications have been administered per physician orders.  How the corrective action (s) will be monitored to ensure the deficient practice will not recite., what quality assurance program will be put into place.  A CQI audit tool will be utilized by the Director of Nursiand/or designee to monitor compliance with medication administration. Audits will be completed weekly X 4 weeks, monthly X 2 months, and quarterly thereafter for at least two quarters until compliance achieved.  Results of these evaluating processes will be presented to the CQI Committee monthly to review for compliance and	he ur, e? ing	
	record for Dec indicated date medication ad These dates in	cion administration cember 2012, s as "circled" on the ministration record. acluded December 14, and 19 [2011].			follow-up. Identified noncompliance may result in development of action plans, s re-education and/or disciplinar action.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 53 of 62

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	COMPL	
		155757	A. BUI B. WIN			03/26/	2012
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE	•	
ROSEGA	ATE VILLAGE				OSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	·ΤΕ	(X5) COMPLETION DATE
	during the exit p.m., the Directindicated if the there had to be medication was nurses are supplied the reverse side [medication and the reason."  Further review as well as the information in the dates were medication.  The resident a order, dated 12 [an antibiotic] 1 tablet by momedication was a.m. and 5:00 2012 medication record had date 5 - 9:00 a.m. a January 6th at	e date is "circled" e a reason the asn't given. "The pose to document on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 54 of 62

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MULT  A. BUILDII  B. WING		00	(X3) DATE S COMPLI 03/26/2	ETED
	PROVIDER OR SUPPLIER		S 7	510 RC	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the dates were Further intervi	related to the reason					
	were not avail to let the phari	"if the medications able, the nurses need macy know the needed 'STAT' they'll ight away."					
	reviewed on 0 Diagnoses inclimited to, ope internal fixation cerebral vascusided residual, These diagnos	for Resident "E" was 3-23-12 at 12:20 p.m. luded, but were not en reduction and on due to fracture, lar accident with left and constipation. es remained current the record review.					
	plan of care, d indicated "Pro constipation d mobility." "A	pproach - approach 1-12 - administer					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 55 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE COMPL	
		155757	A. BUII B. WIN	LDING G		03/26/	2012
NAME OF E	PROVIDER OR SUPPLIER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					OSEGATE DR		
	ATE VILLAGE				APOLIS, IN 46237		715)
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NE	DATE
TAG	A review of the medication adhad a physicial laxative] one by The record had 11th and 12th reverse side of information rethe dates were rethe dates and 29th grams pow. It is medication record had the and 29th [2012] reverse side of the medication reduced rethered rethere	e January 2012 ministration record n order for Senna [a by mouth every day. d the dates of January [2012] circled. The f the record lacked lated to the reason circled.  February 2012 ministration record hysician order, dated Cholestyram 4 Gr. [powder] - a packet e daily before meals. n administration dates February 28th 2] circled. The f the record indicated h was "unavailable"		TAG			DATE
	_	ne 29th [2012] and					
	the pharmacy	had been notified.					
	reviewed on 0. Diagnoses inc	for Resident "D" was 3-23-12 at 9:30 a.m. luded, but were not pertension, severe					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 56 of 62

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	(X2) MUI  A. BUILD  B. WING	DING	NSTRUCTION  00	(X3) DATE : COMPL 03/26/	ETED
	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	failure, congest depression. In admission infollocal area hospinesident had a cancer with a on "chronic Anonsteroidal in diagnoses remittine of the reconstruction of the reconstruction administration 2012 indicated Arimidex was given to the respinous a.m. The medication has prescribed unto no 03-19-12.  During an intestination on the indicated the respinous area in the medication not receiving in the second of the reconstruction of the reconstruction in the medication in the medication in the receiving in the second of the second of the receiving in the second of the receiving in the second of the	primation from the pital indicated the history of breast left mastectomy and rimidex [a nedication]." These ained current at the cord review.  medication record for March at the medication scheduled to be sident every day at record indicated the deen given as il it was discontinued erview on 03-15-12 at the resident's spouse resident had been on a "for years" and now					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 57 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155757		00	COMPLETED  03/26/2012
	PROVIDER OR SUPPLIER  ATE VILLAGE	7510 R	ADDRESS, CITY, STATE, ZIP CODE OSEGATE DR APOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	11:45 a.m., the Director of Nurses indicated the medication had been delivered to the facility - "14 tablets and there were 8 tablets left to send back to the pharmacy." The Medication Administration Record indicated/initialed as dispensed on March 10, 11, 12, 13, 14, 15, 16, 17, 18 and 19th [2012], for a total of 10 doses. During clarification at the daily exit conference on 03-23-12 at 3:00 p.m., if 10 doses were administered, there should only be 4 doses left to be returned to the pharmacy.  On 03-26-12 at 9:00 a.m., the Director of Nurses indicated she spoke with the nurse, who obtained the order to discontinue the medication, and she had indicated to the Director of Nurses that the resident's spouse did not want the resident to have the medication, as the resident had not been on it prior to hospitalization. The Director of Nurses indicated the nurse called the oncologist and left a message regarding the family request. The			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 58 of 62

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	LDING	NSTRUCTION 00	(X3) DATE COMPL 03/26/	ETED
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE DSEGATE DR APOLIS, IN 46237	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	any of the medication over the licensed resident and the resident medication over 03-17-12 and of the licensed resident medication as and the total to pharmacy was seen as a seen of the licensed reviewed on the limited to, influence of the licensed reviewed on the limited to, influence of the limited to, influence of the limited to th	for Resident "F" was 3-23-12 at 11:30 a.m. luded, but were not ammatory colitis, nentia with behaviors in. These diagnoses ent at the time of the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet

Page 59 of 62

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155757	A. BUILDING	00	COMPLETED 03/26/2012
		155757	B. WING		03/26/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
ROSEGA	ATE VILLAGE			NAPOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	The state of the s	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	1	23, 24, 25, 26 and			
	27, 2011. The reverse side of the				
	medication ad	ministration record			
	indicated the	supplement was "not			
	available" on	12-22-11 and			
	12-25-11 and	that the Pharmacy			
	had been cont	acted. The record			
	lacked docum	entation related to the			
other "circled dates."					
	5. Review of	the facility policy on			
		45 a.m., and titled			
		Administration			
		lated as revised			
	· ·	ted the following:			
	7,2011 maica	iod the following.			
	   "PURPOSE []	bold type] To ensure			
	_	resident gets the right			
		the right time in the			
		via the right route. To			
	•	ations are dispensed in			
		nner and to comply			
		I Federal Guidelines			
	i ioi auministra	tion of medications."			
		DE MEDICATION			
		RE: MEDICATION			
		/pe]: If a dose of			
	1	eduled medication is			
	withheld or re	fused by the resident,			
	I .		<u> </u>	<u> 1</u>	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 60 of 62

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  155757	A. BUII	BUILDING 00 WING		COMPLETED 03/26/2012			
NAME OF F	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR						
ROSEGATE VILLAGE					INDIANAPOLIS, IN 46237				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	the nurse will initial and circle the								
	front of the medication record in								
	the space provided for that dose								
	and, an explanatory note must be								
	entered in the nursing notes and/or								
	in the PRN [as needed] nurses								
	notes section of the medication								
	administration record."								
	"Unless medication is ordered as an emergency or specified as a stat medication by the physician, all orders are presumed to be administered on the first scheduled								
	medication time following their								
	arrival at the facility through the								
	normal delivery process."								
	"NOTE: Any specified and reprocedures in a administering resident requires approval by the Committee and	deviation from recommended dispensing or medications to the es documented e Quality Assurance d shall be in ith current statutes							
	This Federal ta	ng relates to							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 61 of 62

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155757	A. BUILDING  B. WING	00	COMPLETED 03/26/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	complaint IN0	0104048.						
	3.1-25(a)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GSG211

Facility ID: 011149

If continuation sheet Page 62 of 62